MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87-e

CERTIFICATE OF DEATH

12180

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 624 W. High St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 624 High St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Owen Raymond Anderson Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Ida J. Anderson

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug. 31 1868

8. AGE: Years	Months	Days	If less than one day
78	3	3	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER — 12. Name: Albert Anderson

FATHER — 13. Birthplace: Caroline Co. Maryland

MOTHER — 14. Maiden name: Anna C. Connelly

MOTHER — 15. Birthplace: Kent Co. Maryland

16. Informant: Mary A. Pennington

Address: High St. Chestertown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/5/46 (month) (day) (year)

Cemetery or crematory: St. Paul

Location: Near Fairlee, Kent Co. Md

18. Funeral director: Wayne A. Williams

Address: Chestertown Maryland.

19. Dec. 5, 1946 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 1946, at 8:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1946, to Dec 3 1946, and that I last saw him alive on Dec 2 1946

Immediate cause of death	DURATION
Coma	1 day
Due to: Degeneration of cerebral cells	1 year
Due to: Arteriosclerosis	4
Other conditions	

(Incinde pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H G Simpson, M. D. or other

Address: Chestertown Date signed: 12 4 46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

STATE OF MARYLAND—CERTIFICATE OF DEATH

12187

(182)

1. PLACE OF DEATH

County Kent — Registration Dist. No. 2010

Village or City near Still Pond — No. — St., — Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds. How long in U.S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Jo Ann Wheatley Beckenstrater — If U. S. Veteran, specify WAR —

(a) Residence: No. Still Pond R.D. St., Ward. (Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS	MEDICAL CERTIFICATE OF DEATH
3. SEX: Female · 4. COLOR OR RACE: White · 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single	21. DATE OF DEATH Dec 25, 1946 (Month) (Day) (Year)
5a. If married, widowed, or divorced HUSBAND of (or) WIFE of —	22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., I last saw h... alive on ..., 19..., death is said to have occurred on the date stated above, at ... m. — Did not attend. Investigated death & signed certificate as suffocated infant.
6. DATE OF BIRTH (month, day, and year) Sept 12-1946	The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: Smothered. Accidental. — Date of onset
7. AGE Years — Months 3 — Days 13 — If LESS than 1 day, ... hrs. or ... min.	
OCCUPATION: 8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. None	
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. None	
10. Date deceased last worked at this occupation (month and year) None · 11. Total time (years) spent in this occupation None	Other Contributory Causes of Importance:
12. BIRTHPLACE (city or town) (State or country) Penna.	
FATHER: 13. NAME Jo Wheatley Beckenstrater	
14. BIRTHPLACE (city or town) (State or country) Washington D.C.	Name of operation None — Date of ...
	What test confirmed diagnosis? None — Was there an autopsy?
MOTHER: 15. MAIDEN NAME Mildred Watson	23. If death was due to external causes (VIOLENCE) fill in also the following:
16. BIRTHPLACE (city or town) (State or country) Paul Smith N.Y.	Accident, suicide, or homicide? Accident — Date of injury None, 19
	Where did injury occur? None (Specify city or town, county and State)
17. INFORMANT Jo Wheatley Beckenstrater (Address) Still Pond R.D. Kent	Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. Home
18. BURIAL, CREMATION, OR REMOVAL Place Downington Pa Date Dec 27, 1946	Manner of injury Smothered in Bed
	Nature of injury —
19. UNDERTAKER B R Fellows (Address) Still Pond Md	24. Was disease or injury in any way related to occupation of deceased? No — If so, specify Frank Hines
20. FILED 12-27, 1946 J Mellart, Registrar.	(Signed) Deputy Med. Exam. Kent Co. M.D. (Address) Chestertown Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106-B)

CERTIFICATE OF DEATH

★ 12188

Reg. Dist. No. 2000

1. PLACE OF DEATH:

County: Kent

City or town: Olivers Hill Near Galena
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Kent

City or town: Olivers Hill Rural Galena Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth Caulk

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband or wife: Irving Caulk

6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): July 2, 1896

8. AGE: Years: 50 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Kent Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: George Burpkin

13. Birthplace: Md.

MOTHER 14. Maiden name: Sarah Collins

15. Birthplace: Md.

16. Informant: Irving Caulk

Address: Rural Galena Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 9/46 (month) (day) (year)

Cemetery or crematory: Olivers Hill Near Galena

Location: Olivers Hill Near Galena

18. Funeral director: Edward Kellam

Address: Millington Md.

19. 12-9 1946 (Date rec'd by registrar) Elizabeth J. Mumford Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 6 1946, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 P.M. DECEMBER 6 1946, to 6.30 P.M. DEC 6 1946

and that I last saw her alive on DECEMBER 6 1946

Immediate cause of death: BRONCHIAL ASTHMA — DURATION: 6 YRS

Due to:

Due to:

Other conditions: BRONCHIECTASIS HYPOTENSION
(Include pregnancy within 3 months of death)

Major findings of operations: NO SURGERY — Date of op.

Autopsy results: NO AUTOPSY

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Theodore F. Paprocki M.D.
M. D. or other

Address: Galena Md. Date signed 12-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-6)

CERTIFICATE OF DEATH

★ 12189

Reg. Dist. No. 2020

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48 hours
Hospital, Institution, or street address where death occurred:
Kent and Queen Anns
How long in hospital or institution? 48 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rock Hall
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ellanora Christian

3.(b) Social Security Number: I68-I6-34I4

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John R. Christian
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1883 1883

8. AGE: Years	Months	Days	If less than one day
63	9	24	..... hrs. ..... min.

9. Birthplace: Quaker Neck, Kent Co., Maryland
(Town, county, and state)
10. Usual occupation: Housewife and cannery worker
11. Industry or business

FATHER
12. Name: Edward Crew
13. Birthplace: England

MOTHER
14. Maiden name: Mary Cannon
15. Birthplace: Maryland

16. Informant: Mrs. Grace Tibbett
Address: Cannon St. Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 15, 1946 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. Dec. 14, 1946 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 13 1946, at ..... P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 1946, to December 13 1946
and that I last saw her alive on December 13 1946

Immediate cause of death	DURATION
Carcinoma of stomach	1 year ?
Stock	6 hours
Due to: operation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of stomach
Date of op. 12-12-46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. C. Dick M. D. or other
Address: Chestertown, Md. Date signed: 12-13-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-8)

12190

CERTIFICATE OF DEATH

Reg. Dist. No. 2030

1. PLACE OF DEATH:
County: Kent
City or town: Piney Neck.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Piney Neck. Rock Hall RR
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Annie Marie Elburn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widow

6.(b) Name of husband or wife: Bennie Isaac Elburn
6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): January 17. 1879

8. AGE:

Years	Months	Days	If less than one day
67	11	4	hrs. min.

9. Birthplace: Piney Neck. Rock Hall. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Washington Elburn
13. Birthplace: Rock Hall.

MOTHER
14. Maiden name: Mollie Beck
15. Birthplace: Rock Hall

16. Informant: Mrs. Beulah Elburn
Address: Rock Hall RR

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 24. (month) (day) (year)
Cemetery or crematory: Worley Chapel
Location: Rock Hall Md

18. Funeral director: Edgar L. Faner.
Address: Edwin Hill Md

19. Dec 21 1946 (Date rec'd by registrar) S. Elwood Burgess Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 21 1946, at 9:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1943, to Dec. 21 1946
and that I last saw h- alive on December 21 1946

Immediate cause of death	DURATION
Acute Myocarditis	6 Days
Due to: Cerebral Hemorrhage	3 days
Due to: Malignant Hypertension	3 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lemuel W Smith M. D. or other
Address: Chestertown, Md Date signed Dec 21/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (69)

CERTIFICATE OF DEATH

Reg. Dist. No. 1219 2020

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
Crew Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: [redacted]

3.(a) FULL NAME: Miss. Belle Emory

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1872

8. AGE: Years	Months	Days	If less than one day
74	8	7	hrs. min.

9. Birthplace: Kent Co. Maryland
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business
FATHER 12. Name: Robert S. Emory
13. Birthplace: Queen Anne Co. Maryland
MOTHER 14. Maiden name: Julianna Wilkins
15. Birthplace: Kent Co. Maryland
16. Informant: Crew Nursing Home Records
Address: Chestertown, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 21 1946 (month) (day) (year)
Cemetery or crematory: Chester Cem.
Location: Chestertown, Md.
18. Funeral director: J. Willis Wells
Address: Chestertown, Md.
19. Dec. 21 1946 (Date rec'd by registrar) Chas. L. Bruce, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1946, at 7.30 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 19 45 to Dec 20 19 46
and that I last saw h[illegible] alive on Dec 20 1946

	DURATION
Immediate cause of death: Pulmonary Edema	yrs.
Due to: Congestive Heart	
Due to: Stroke	
Other conditions: Pellagra	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: None Injured at work?

23. SIGNATURE: Frank L. Jones M.D.
Address: Chestertown Md. M. D. or other
Date signed: Dec 21 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

12192

CERTIFICATE OF DEATH

Reg. Dist. No. 2020

1. PLACE OF DEATH:
County Kent
City or town Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life time
Hospital, institution, or street address where death occurred: 349 High St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Chestertown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 349 High St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Lydia Tunkard Fowler

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 12, 1863

8. AGE:

Years	Months	Days	If less than one day
83	1	19	..... hrs. ..... min.

9. Birthplace Chestertown, Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Byron D. Fowler
13. Birthplace Chestertown Md

MOTHER
14. Maiden name V. Adelaide Frazier
15. Birthplace Chestertown

16. Interment Wesleyan C. Fowler
Address Chestertown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 3 1946 (month) (day) (year)
Cemetery or crematory Chester
Location Chestertown, Maryland

16. Funeral director Marvin V. Williams
Address Chestertown, Maryland

19. Dec. 3 1946 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 1st, 1946, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1946, to November 30 1946, and that I last saw h— alive on December 30 1946.

Immediate cause of death

	DURATION
Cardiac Insufficiency	11 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Lewis W. Smith, M. D. or other
Address Chestertown, Md Date signed Dec 1/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

12193

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all lye

Hospital, institution, or street address where death occurred:

Kent St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Chestertown

(If ontside city or town limits, write RURAL and give nearest town)

Street No. 200 Kent St

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME: Charles Henry Gland

3. (b) Social Security Number: 216-05-6701

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Ollie Gland

8.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): January 10, 1892

8. AGE:

Years	Months	Days	If less than one day
54	11	13	..... hrs. ..... min.

9. Birthplace: Chestertown, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Miscellaneous

FATHER — 12. Name: Douglas Gland

FATHER — 13. Birthplace: Quaker Neck, Maryland

MOTHER — 14. Maiden name: Tamar Jones

MOTHER — 15. Birthplace: Chestertown, Maryland

18. Informant: Tamar Gland (Mother)

Address: Chestertown Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/26/46 (month) (day) (year)

Cemetery or crematory: Chestertown - Quaker Neck

Location: Near Chestertown, Maryland.

18. Funeral director: Marion V. Williams

Address: Chestertown, Maryland

19. Dec. 26, 1946 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23 1946, at 12:15 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12-22 1946, to 12-23 1946

and that I last saw h. alive on 12-23 1946

Immediate cause of death	DURATION
Pulmonary edema	3 hours
Due to: arterial hypertension	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R Rest M Barnes M. D. or other

Address: Chestertown Md. Date signed Dec 26, 1946

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (5th)

CERTIFICATE OF DEATH

12194

Reg. Dist. No. 2030

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred: Grays Inn

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Grays Inn

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: James B. Kauffman

3.(b) Social Security Number: 212-07-2428

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Theresa Kauffman

6.(c) If alive, give age: Cat years

7. Birth date of deceased (mo., day, yr.): April 26 1887

8. AGE: Years	Months	Days	If less than one day
59	7	14	hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: retired painter

11. Industry or business: self

FATHER

12. Name: Charles B. Kauffman

13. Birthplace: not known

MOTHER

14. Maiden name: Sevilla Kopenhaver

15. Birthplace: Hagerstown Md.

16. Informant: Mrs Theresa Kauffman

Address: Rock Hall, Md

17. Burial, cremation, or removal. Which?: Burial Date thereof: 12-12-46 (month) (day) (year)

Cemetery or crematory: David Ridge

Location: Baltimore Md

18. Funeral director: L. Willis Ferrell

Address: Chestertown Md

19. 12/10/46 (Date rec'd by registrar) 19 S. Elwood Burgard Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 19 46, at 12 40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 11 P.M 19 46, to Dec 10 19 46

and that I last saw him alive on 12-9. 19 46

Immediate cause of death	DURATION
(a) Angina pectoris	
Due to: (b) Chron Myocarditis	
Due to: (c) Ca of prostate and bladder	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca of prostate and bladder Date of op. Nov 46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State) — — —

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work? —

23. SIGNATURE: Elwood A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 12/10/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

12195

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: Queen St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Emma Agnes Knight

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 2, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	25	..... hrs. ..... min.

9. Birthplace: Cecil Co. Maryland (Town, county, and state)
10. Usual occupation: bookkeeper (retired)
11. Industry or business

FATHER
12. Name: Wm. O'B. Knight
13. Birthplace: Penna,

MOTHER
14. Maiden name: Joanne Morgan
15. Birthplace: Maryland

16. Informant: Mr. Wm. O'B. Knight
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 28, 1946 (month) (day) (year)
Cemetery or crematory: Chester Cem.
Location: Chestertown, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Md.

19. Dec 28 1946 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25 1946 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/23/46 to 12/25 1946 and that I last saw her alive on 12/25/46

Immediate cause of death	DURATION
Cachexia and	3 months
Due to Abdominal carcinomatosis	6 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: peritoneal transplants from carcinomatous ovarian cyst which lead to obstruction. Date of op. Approx Sept 1, '46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or Coroner
Address: Chestertown, Md. Date signed: 12/26/46

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-B)

12196

CERTIFICATE OF DEATH

Reg. Diat. No. 2010

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Kentmore Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Kennedyville R.D 4
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Kentmore Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Kennedyville R.D
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish War Veteran

3.(a) FULL NAME: Conrad D. Des Ramps

3.(b) Social Security Number: 213-22-819

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Etta M Des Ramps
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Aug. 23 1877

8. AGE: Years	Months	Days	If less than one day
69	4	7	hrs. min.

9. Birthplace: Orangetown N.Y. (Coldeham)
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Conrad D. Des Ramps.
13. Birthplace: Unknown.

MOTHER
14. Maiden name: Eliza MacDonald
15. Birthplace: Scotland

18. Informant: Mrs Etta M Des Ramps
Address: Kentmore Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 2 1947 (month) (day) (year)
Cemetery or crematory: Shrewsbury
Location: Near Kennedyville Maryland
18. Funeral director: Maud L. Williams
Address: Chestertown Md

19. Jan 2 1947 (Date rec'd by registrar) J. H. Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1946, at 1:30 A. M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from November 20 1946, to Dec 29 1946
and that I last saw him alive on Dec 29 1946

	DURATION
Immediate cause of death: Myocardial Decompensation	2 DAYS
Due to: Chronic Myocarditis —	
Arteriosclerotic Heart Disease and	
Due to: Hypertensive Cardio Vascular Disease	5 YRS
Other conditions: Chronic Nephrosis with Hypoproteinemia	2 YRS

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Theodore F. Papuchi M.D
M. D. or other
Address: Galena Date signed: 12-31-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-a)

CERTIFICATE OF DEATH

12197

Reg. Dist. No. 2020

1. PLACE OF DEATH:
County: Kent
City or town: near - Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Chestertown - R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Katherine P. Mc Kee

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1864

8. AGE: Years	Months	Days	If less than one day
82	3	4	hrs. min.

9. Birthplace: Kent Co. Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Daniel McKee
13. Birthplace: Ireland

MOTHER — 14. Maiden name: Hannah Braceland
15. Birthplace: Ireland

16. Informant: Miss. Annie Mc Kee
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 31, 1946 (month) (day) (year)
Cemetery or crematory: Chester Cem.
Location: Chestertown, Md.

18. Funeral director: J. Willis Wells
Address: Chestertown, Maryland

19. Dec. 30 1946 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1946, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 12 1946, to Dec. 27 1946 and that I last saw h[illegible] alive on Dec 27 1946

Immediate cause of death	DURATION
Cardiac Failure	2 days
Due to: Senile	3 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank H. Smith, M. D. or other
Address: Chestertown Date signed: 12/28/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

12198

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-L)

CERTIFICATE OF DEATH

Reg. Dist. No. 2030

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dunbeigh

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: George Lewis Mench

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emily Mench

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Jan 7 1881

8. AGE:

Years	Months	Days	If less than one day
65	10	27	...hrs. ...min.

9. Birthplace: R Worton, Md. (Town, county, and state)

10. Usual occupation: Storekeeper

11. Industry or business: own

FATHER — 12. Name: Joseph Lewis Mench

FATHER — 13. Birthplace: Worton, Md.

MOTHER — 14. Maiden name: Maryland Willis

MOTHER — 15. Birthplace: Broadneck P.O. Chestertown

16. Informant: Mrs Emily Mench

Address: Rock Hall, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 8. 1946 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Rock Hall Md.

18. Funeral director: Edgar L. Lane

Address: Church Hill Md

19. Dec 6. 1946 (Date rec'd by registrar) S. Elwood Bowers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 1946, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 1946, to Dec. 4 1946 and that I last saw h... alive on Dec 1946

Immediate cause of death	DURATION
Carcinoma of stomach and liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State) — — —

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall Md Date signed: 12/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-a)

CERTIFICATE OF DEATH

12199

Reg. Dist. No. 2025

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Kent
City or town: Pomona
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred: Chestertown R.D. # 3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: (Not) Pomona
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chestertown R.F.D. # 3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Marion S. Parsons

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: (Late) Ella Parsons
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 27, 1886

8. AGE: Years	Months	Days	If less than one day
60	4	2	hrs. min.

9. Birthplace: Worton, Kent Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm
FATHER 12. Name: Thomas Parsons
13. Birthplace: Kent Co. Maryland
MOTHER 14. Maiden name: Eliz. Jarvis
15. Birthplace: Kent Co. Maryland
16. Informant: M. Walter Parsons
Address: Chestertown R.D. # 3
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/46 (month) (day) (year)
Cemetery or crematory: Chest
Location: Chestertown, Maryland
18. Funeral director: Marie V. Williams
Address: Chestertown, Maryland
19. Dec. 31 1946 (Date rec'd by registrar) Clara L. Barnes, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 19 46 at about 4 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Did not attend 19 to 19 and that I last saw h alive on 19
Immediate cause of death: Coronary Thrombosis — DURATION: Months
Due to: Arterio Sclerosis — DURATION: Yrs.
Due to: — DURATION: Yrs.
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: None — Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. Signature: Roger Hynson M.D. Asst. Med Exam Kent Co. M. D. or other
Address: Chestertown Md. Date signed: 12-29-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

122111

Reg. Dist. No. 2020

1. PLACE OF DEATH:
County Kent
City or town Worton Md Rural Butlertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Kent
City or town Worton Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mile to Da
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Levi Seeney

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Veronia Seeney
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Mar 16 1876

8. AGE:

Years	Months	Days	If less than one day
70	10	3	hrs. min.

9. Birthplace Butlerton Rural Worton Md (Town, county, and state)
10. Usual occupation Farm work
11. Industry or business Farm

MOTHER
12. Name Richard Seeney
13. Birthplace Butlertown Rural Worton Md

FATHER
14. Maiden name Henretta Butler
15. Birthplace Butlertown Rural Worton Md

16. Informant Veronia Seeney
Address Worton Md Rural Butlertown

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 1946 (month) (day) (year)
Cemetery or crematory Mount Olive
Location Butlertown Rural Worton Md

18. Funeral director B R Fellows
Address Still Pond Md

19. Dec 21 1946 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19 1946, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946, to Dec 19 1946
and that I last saw him alive on Dec 14 1946

Immediate cause of death	DURATION
Chronic Endo-Myocarditis	
Secondary Anemia	
Due to: Elder Bronchitis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert A Burgard M. D. or other
Address Rock Hall, Md Date signed 12/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

CERTIFICATE OF DEATH

★ 12201 Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Kent
City or town: Near - Fairlee
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred: Chestertown R.D. # 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Fairlee
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Chestertown R.D # 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Anne Stoops

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Howard A. Stoops
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): October 29 1878

8. AGE:

Years	Months	Days	If less than one day
68	1	23	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Samuel Witzel
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Unknown.
15. Birthplace:

16. Informant: Mr. Howard A. Stoops, Husband
Address: Chestertown R.D. # 2 Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/24/46 (month) (day) (year)
Cemetery or crematory: St. Paul
Location: Near - Fairlee Kent Co. Md.
19. Funeral director: Warren F. Williams
Address: Chestertown, Maryland

19. Dec. 24 1946 (Date rec'd by registrar) Clara S. V. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1946, at 10:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946, to Dec 22 1946
and that I last saw h.er alive on 12-22 1946

Immediate cause of death	DURATION
Chron. Endo-Myocarditis	
Decompensation	
Due to: Chron. Arthritis	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: A. A. Burgard M. D. or other
Address: Rockhall Date signed: 12/28/46

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

12202

Reg. Dist. No. 2020

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nettie Moody Thompson

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Jacob Thompson
living 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. I7, I868

8. AGE: Years	Months	Days	If less than one day
78	3	22	..... hrs. ..... min.

9. Birthplace: Kent Co. Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: James T. Moody
13. Birthplace: Maryland
MOTHER 14. Maiden name: Virginia ~~Moody~~ Hynson
15. Birthplace: Maryland
16. Informant: Mrs. Merrick Clements
Address: Chestertown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. II, I946 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Md.
18. Funeral director: J. Willis Wells
Address: Chestertown, Md.
19. Dec. 11, 1946 (Date rec'd by registrar) Clara S. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 9.1946 19..... at 9.40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 19.1946 to Dec.9.1946
and that I last saw h...er alive on December 91946

Immediate cause of death	DURATION
Malnutrition	
Due to: Anemia	
Due to:	
Other conditions: Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: David Jones M. D. or other
Address: Chestertown Md Date signed: DEC 10/46

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